Using the ASAM Criteria to Guide Assessment and Treatment of Youth

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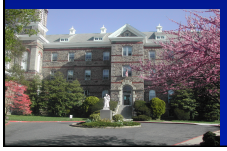


JOHNS HOPKINS MEDICINE
SCHOOL OF MEDICINE

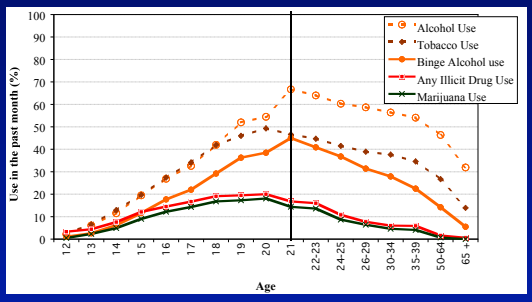
Housekeeping

- Approved for 1 hour SUD Continuing Education Units
- A recording of this webinar and slides will be posted on: https://idph.iowa.gov/substance-abuse/families-in-focus
- Survey following the webinar and 30-day follow-up

Outline

- The basics: Intro to the ASAM Criteria
- ASAM Criteria assessment dimensions as a roadmap for treatment
- Placement in level of care
- Case discussion

Relationship between Past Month Substance Use and Age



Source: Dennis (2002) and 1998 NHSDA.

ASAM CRITERIA

PATIENT PLACEMENT CRITERIA (PPC)

Using multidimensional assessment to guide treatment

ASAM Patient Placement Criteria (PPC) Assessment Dimensions

1: Intoxication / Withdrawal Potential
2: Biomedical Conditions
3: Emotional / Behavioral / Cognitive Conditions
4: Readiness to Change
5: Relapse / Continued Use / Continued Problem Potential
6: Recovery Environment

DIMENSION 4
READINESS TO CHANGE

Treatment Engagement:
What Do Adolescent Addiction Patients Want?

- What you're selling:
  - Long term solutions
  - Function
  - Abstinence
- What they're shopping for:
  - Crisis relief
  - Better drugs, more trouble-free partying
  - Comfort
  - Get some meddling adult off my back

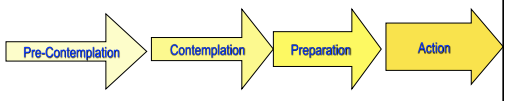
ENGAGEMENT

- Why is <u>this</u> patient presenting for treatment <u>now</u>?
  - Our version
  - Their version

Treatment Engagement

- Treatment readiness
- Meeting the patients where they are
- Discovery vs recovery
- Prehab vs rehab

Treatment Engagement
Stages of Change



- Progressive treatment engagement
- Role induction
- Motivational enhancement

Motivational approaches

- Do you know other people who have been in trouble…
- Do you know why I or your loved ones might think it's a problem…
- What are the pro's and con's for you…
- What would be evidence in your view that it's a problem…
- If you could stop anytime, would you be willing to see what it's like…
- Let's schedule you to come back and see how it's going…

Extra active ingredients – engagement, relationship, monitoring

- Care providers have enormous impact on patients and families
- Important to set clear standard: our stance should be that any intoxicant use is unhealthy
- Longitudinal follow-up can hold up a mirror of dynamic change, both pos and neg

DIMENSION 1
INTOXICATION / WITHDRAWAL POTENTIAL

ASAM Criteria Dimension 1 Considerations (Withdrawal / Intoxication)

Examples by Drug Class

- Marijuana withdrawal: insomnia and irritability
- Marijuana intoxication: persistent memory and thinking problems
- Opioid withdrawal: physical sickness and severe craving
- Any intoxication: agitation, psychosis
- Inhalant intoxication: subacute delirium and disorganization
- Stimulant withdrawal: depression and severe craving
- Hallucinogen induced persisting perceptual distortion syndromes

Detoxification

- Opioid withdrawal
  - Need for medications
  - Usually inpatient
- Alcohol withdrawal – dangerous but infrequent in youth
- All substances – attention to sleep
- All substances – discontinuation of an engrained habit needs special focus

Detoxification

- Can be a revolving door, but it should lead somewhere
- Detoxification necessary but insufficient – motivational moment for linkage to continuing care
- Opportunity for relapse prevention medications when appropriate

DIMENSION 2
BIOMEDICAL CONDITIONS AND COMPLICATIONS

ASAM PPC
Dimension 2 Considerations

- Severe biomedical conditions
  - Traumatic injuries
  - Seizures
  - HIV, HBV, HCV
  - Sequelae of injection use
  - Overdose

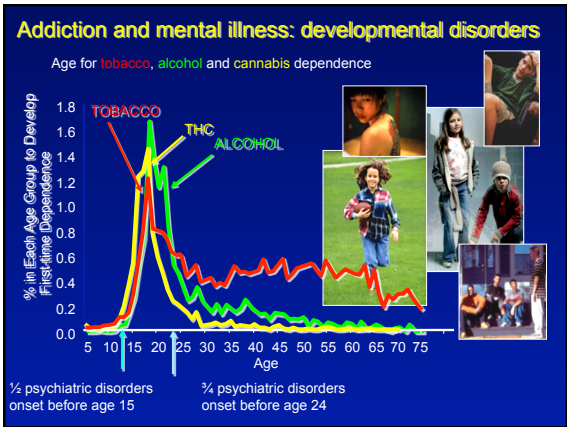
ASAM PPC
Dimension 2 Considerations

- Other biomedical conditions
  - Asthma (reactive airways disease)
  - STDs (urethritis, cervicitis, chlamydia, gonorrhea, syphilis)
  - Exacerbation of chronic illness
  - Pregnancy (Don't forget contraception)
  - Poor nutrition (both malnutrition and obesity)
  - Anemia
  - Dental problems
  - Gastritis
  - General health maintenance
  - Chronic pain

Medical Co-morbidity

- Where are the doctors and other general health care providers?
- How do we collaborate with them?

DIMENSION 3
EMOTIONAL / BEHAVIORAL / COGNITIVE CONDITIONS AND COMPLICATIONS



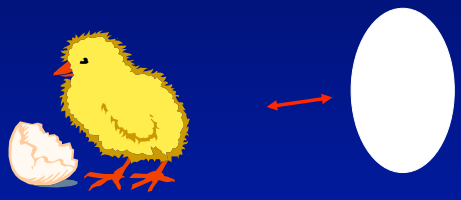
Dual Diagnosis
Cast the net wide

- High prevalence of co-morbidity
- Inclusion of symptoms and sub-syndromal problems without requiring formal diagnosis
- Pre-morbid, drug-induced, and drug exacerbated conditions
- Suspect co-occurring psychiatric disorders
- Treat co-occurring psychiatric disorders

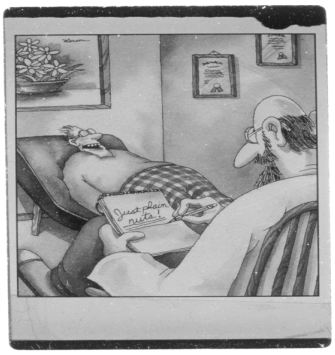
Adolescent Dual Diagnosis Greatest Hits

- Major Depression
- Depression NOS
- Dysthymia
- Bipolar Disorder
- Mood Disorder NOS
- Disruptive Mood Dysregulation Disorder
- Oppositional Defiant Disorder
- Conduct Disorder
- Intermittent Explosive Disorder
- Impulse Control Disorder NOS

Dual Diagnosis
Which Comes First?



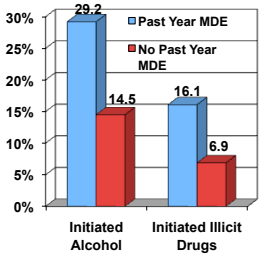
The Psychiatric View of Our Patients



Subdomains for Assessment of Severity and Risk in Dimension 3

- Dangerousness / Lethality
- Interference with Recovery Efforts
- Social Functioning
- Ability for Self Care
- Course of Illness

Past Year Major Depression Associated with Initiation of Substances

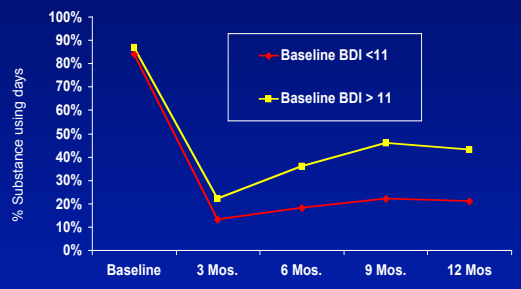


Among youth 12 - 17:

- Past year initiation of alcohol - 15.4%
- Past year initiation of illicit drugs - 7.6%
- Past year major depression - 8.8%

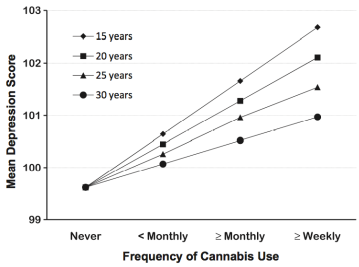
SAMHSA. National Survey on Drug Use and Health. NSDUH Report 5-07 (2005 data).

Depressive Symptoms Correlate with Substance Use Outcomes



Psychiatric consequences of cannabis

MJ use associated with depressive symptoms

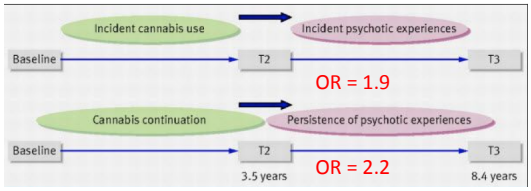


Pooled data, 4 longitudinal studies, n=6900

Horwood et al. Drug and Alcohol Dependence *126 (2012) 369–378*

Cannabis and psychosis
Prospective exposure cohort study

- 10 yr prospective cohort of 1923 German youth (14-24 at baseline)
- Examination of change over 3 time points



Kuepper et al British Med J. 2011

Cannabis and cognitive impairment

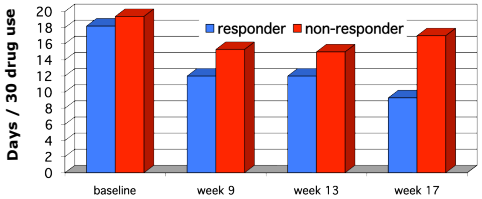
- IQ measured age 13, 38; N=1037
- MJ use measured age 18, 21, 26, 32, 38
- IQ decline associated with regular use and dependence, dose response related to persistence

	None	Some use	1 wave	2 waves	3+ waves
Regular use	+1	-1	-3	-2	-5
Dependence	+1	-1	-2	-3	-6

- No difference with controls for education, recent use, other substances, schizophrenia
- Adolescent onset worse, -8 points for 3+waves

Meier et al. PNAS. 2011

Reductions in substance use associated with reductions in depression



Both Placebo (p<.0001) and Fluoxetine (p<.0003) Responders have significant pre-post reduction whereas Non-Responders in each group do not

Responders differ significantly from Non-Responders (p < .02)

Riggs et al.

DIMENSION 5
RELAPSE / CONTINUED USE / CONTINUED PROBLEM POTENTIAL

Dimension 5 Assessment Domains

- History and pattern of use
- Response to drug effects
- Response to triggers (internal and external)
- Cognitive and behavioral measures of strengths and weaknesses

Dimension 5
History and pattern of use

- Specific substances used
- Duration of use
- Amount of use
- Frequency of use
- Pattern of change
  - Abstinence and relpase
  - Response to intervention

Dimension 5
Response to substance effects

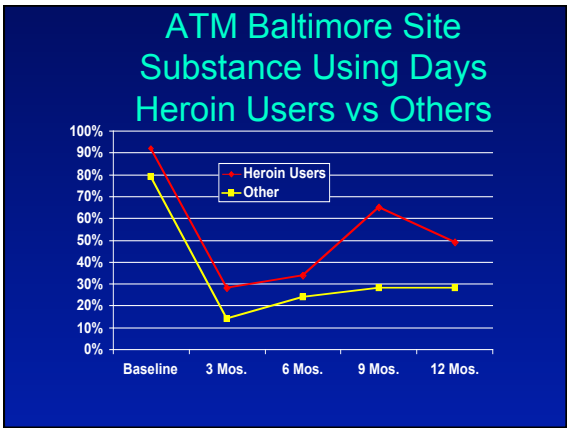
- Positive reinforcement (reward craving)
- Negative reinforcement (relief craving)

Dimension 5
Response to internal and external stimuli

- Response to cues or triggers
- Response to acute and/or chronic stressors

Dimension 5
Features of temperament, vulnerability and resilience

- Locus of control and self efficacy
- Coping skills
- Impulsivity
- Goal orientation and stance
  - Assertive
  - Compliant
  - Passive
  - Passive Aggressive
  - Oppositional



Features of youth opioid treatment

- Developmental barriers to treatment engagement
  - Invincibility
  - Immaturity
  - Motivation and treatment appeal
  - Salience of burdens of treatment
- Variable effectiveness of family leverage (or not)
- Pushback against sense of parental dependence and restriction
- Prominence of co-morbidity

Medications for youth opioid treatment

- Buprenorphine clearly effective for youth, extended release naltrexone very promising
- But engagement and adherence problematic
- Recommendation: integration of relapse prevention medication into comprehensive care
- Developmentally informed specialty programming essential

Responding to lapse and relapse

- Multiple treatment episodes is the norm for SUD and co-occurring disorders
- Not a personal or treatment failure
- Encourage honest reporting
- What are we going to do different?

DIMENSION 6

RECOVERY ENVIRONMENT

Family

- Family influences are critical
  - Both positive and negative
  - Family drug use
  - Family attitudes towards drug use
  - Family values
- Adolescents rely substantially on the support of adults
  - General parenting and support
  - Monitoring and supervision
  - Treatment support

Modeling of Behavior

- Kids mimic what they see
- Kids learn from experience, more than from explanation
- No matter what you say, they will do what you do

Unrealistic parenting interventions

Dimension 6 Considerations

Substance use within social network

- Household substance use
- Romantic partner substance use
- Peer substance use
- Substance infested communities

Dimension 6 Considerations
Influences on recovery

- Chaotic home life
- Domestic violence
- Homelessness
- Anti-social influences
- Economic sufficiency
- Abuse and neglect

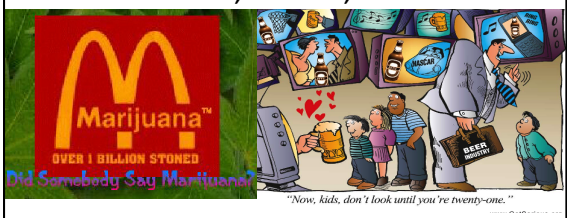
Dimension 6 Considerations
Support for treatment

- Active support for treatment
  - Supervision
  - Monitoring
  - Enthusiasm and cheerleading
  - Assistance (eg transportation, payment, participation etc)
- Neutral acceptance but without ability to support
- Opposition or undermining

Dimension 6 Considerations
Burdens of treatment

- Work
- Childcare
- Transportation
- Financial
- Time

Overcoming Barriers -- Attitudes, Access, Culture



- "No big deal"
- "It's natural"
- "We used it when we were kids"
- "They should learn to drink at home"
- "Every kid drinks a little beer"

Overcoming Barriers Mixed Messages

- Which is right?
  - Zero tolerance - nothing but abstinence
  - Delaying initiation
  - Normative experimentation
  - Free disclosure of use
- Yes

Not In My House

- Address the supply:
  - Monitor and secure medications
  - Dispose of medications no longer in use
  - Coordinate with peers, friends, parents, grandparents
- Parental Use? (tricky territory)
  - Remind them that kids are mimics
  - "Not that this applies to you, but some families may use substances socially…"

LEVEL OF CARE PLACEMENT

ASAM PPC Levels of Care

Level 0.5:	Early Intervention
Level 1:	Outpatient
Level 2:	Intensive Outpatient and Partial Hospital
Level 3:	Residential / Inpatient
Level 4:	Hospital

ASAM Criteria Crosswalk

	I. Outpatient	II. Intensive Outpatient	III. Residential	IV. Medically Managed Inpatient
Withdrawal	No risk	Minimal	Some risk	Severe risk
Medical	No risk	Manageable	Medical monitoring required	24 hr acute medical care required
Emotional/ Behavioral	No risk	Mild severity	Moderate	24 hr psychiatric care required
Readiness To Change	Cooperative	Cooperative but requires structure	High resistance, needs 24 hr monitoring	
Relapse Potential	Maintains abstinence	More symptoms, needs close monitoring	Unable to control use in outpt care	
Recovery Environment	Supportive	Less support, but can cope with structure	Danger to recovery, logistical incapacity for outpt	

Rationale for level of care

- Appropriate intensity
- Appropriate modalities and service components
- Inpatient vs outpatient
- Flexible movement up and down levels
- Any treatment is a good start…

Considerations for level of care Dim 1

- Medical detox needs residential
- Dangerous persistent intoxication needs residential
- Withdrawal with non-medical detox needs higher LOC

Considerations for level of care Dim 2

- Physical symptoms need access to medical care
- Severe medical illness needs residential if manageable there
- Pregnancy may need residential

Considerations for level of care Dim 3

- Dangerousness needs residential
- Psychiatric problems need access to mental health/psychiatric evaluation and treatment
- Mental health severity needs “dual diagnosis enhanced” services and higher LOC
- Persistent mental health problems needs longer duration

Considerations for level of care Dim 4

- Low motivation sometimes needs higher intensity
- But persuasion sometimes works better with gradual exposure over longer at lower intensity
- High motivation sometimes needs lower intensity
- But sometimes can take advantage of higher intensity for the right opportunity

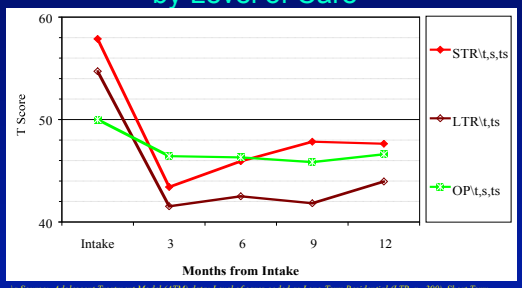
Considerations for level of care Dim 5

- Dangerous use, more consequences needs higher LOC
- Difficult to interrupt use needs higher LOC
- Opioids need higher LOC

Considerations for level of care Dim 6

- Lack of family support needs higher intensity, higher LOC
- Family disorganization needs higher *family* intervention intensity

Adolescent Treatment Models (ATM) Change in Substance Frequency Index by Level of Care



a Source: Adolescent Treatment Model (ATM) data: Level of cares coded as Long Term Residential (LTR, n=390), Short Term Residential (STR, n=594), Outpatient/Intensive and Outpatient (OP/IOP, n=560);. T scores are normalized on the ATM outpatient intake mean and standard deviation. Significance (p<.05) marked as 't for time effect, 's for site effect, and 'ts for time x site effect.

CASE ILLUSTRATION

Adolescent Case History (I)

- 16 girl referred from detention for evaluation
- Substances: MJ onset 12, progressing to daily by 15. Alcohol onset 13, with weekend binges to severe intoxication. Sporadic experimentation with nasal cocaine, hallucinogens, and prescription opioids. Abstinence by confinement while in detention for the past 3 weeks. Had a few sessions of substance abuse counseling several months ago, but mostly no show because family couldn't "make her" attend.
- Family: Lives with GM. F incarcerated, little contact. M hx addiction and "breakdown".

Adolescent case history (I)

- Personal: Allegation of molestation by neighbor age 9. Sexually active since 13, 8 lifetime partners, current unprotected sex with older boys, often while intoxicated. Poor school performance, repeated 3rd grade, told she was a "slow learner," no special ed services, multiple suspensions for disruptive behavior, assigned to 10th grade but truant most of year. Most friends are involved with drugs and delinquent behaviors.
- Medical: Asthma, hx of chlamydia, S/P spontaneous abortion, chronic stomach aches.
- Legal: Arrested CDS possession school grounds 14, charges dropped. Received probation 14 for assault. House arrest 15 for CDS intent to distribute. Detention 3 weeks ago for VOP theft and UUV.

Adolescent case history (I)

- Psychiatric: Inattention and hyperactivity since childhood, no tx. Chronic emotional lability and dysphoric mood, tantrums, explosive temper, much worse since onset of substance use past few years. Progressively oppositional and ungovernable at home. Stays away from home habitually until late and ran away overnight once. Chronic nighttime insomnia and sleeping late, with sleep-wake cycle disruption. Says MJ helps her "chill" and avoid fights with peers. Several attempts at family and school counseling, but never sustained. No formal psych evaluation. Insomnia and irritability worse since discontinuation of MJ 3 weeks ago.

Dimensional Assessment, Treatment Service, And Placement Considerations

Dimension 1

- *Assessment*. Abstinent for 3 weeks, some mild "subacute" persistent abstinence effects of insomnia and irritability.
- *Treatment Service Needs*. Needs education re sleep hygiene and insomnia as potential relapse trigger. Consider mild temporary sleep aid (eg diphenhydramine or low-dose trazodone).
- *Placement*. Dimensional service needs met by Level I placement (and could be addressed in any level of care).

Dimensional Assessment, Treatment Service, And Placement Considerations

Dimension 2

- *Assessment*. No acute problems.
- *Treatment Service Needs*. Needs general health maintenance. Needs STD screening, contraception services and sexual risk behavior counseling. Consider exacerbation of reactive airways disease from heavy MJ use.
- *Placement.* Dimensional service needs met by Level I placement.

Dimensional Assessment, Treatment Service, And Placement Considerations

Dimension 3

- *Assessment*. Significant affective disturbance without evaluation or treatment. No imminent dangerousness. Social functioning significantly impaired in the school, legal and family domains. Emotional/behavioral symptoms have caused severe interference with addiction recovery efforts through lack of cooperation with treatment, deviant peer group affiliation, and self-professed psychological benefits of substance use. Impaired ability for self care characterized by ongoing sexual risk behaviors.
- *Treatment Service Needs.* Needs psychiatric evaluation, including consideration of treatment for affective disorder. Needs programmatic treatment setting for implementation and close monitoring of psychiatric treatment (pharmacological and/or psychotherapeutic). Needs at least moderately high intensity daily structure and assessment of behavioral response.

Dimensional Assessment, Treatment Service, And Placement Considerations

Dimension 3

- *Placement.* Dimensional service needs probably met by Level II.5 placement with psychiatric treatment either built into the substance abuse program or provided through coordinated psychiatric services. (Consideration might reasonably be given to a Level III.5 placement, especially if additional details of assessment or lack of progress at Level II.5 suggest the need for higher intensity including 24 hr structure and boundaries unavailable in the home environment to prevent further deterioration of social functioning.)

Dimensional Assessment, Treatment Service, And Placement Considerations

Dimension 4

- *Assessment.* Currently in pre-contemplative stage of change. Sees herself as having a probation officer problem but not a substance problem.
- *Treatment Service Needs.* Needs significant treatment frequency, intensity and a programmatic milieu to support motivation and progression through the stages of change. Needs motivational enhancement therapy (MET) techniques including functional analysis of pros and cons of substance use, as well as juvenile justice leverage (such as probationary mandate) to improve treatment engagement.
- *Placement.* Dimensional service needs met by Level II.5 placement.

Dimensional Assessment, Treatment Service, And Placement Considerations

Dimension 5

- *Assessment*. Despite brief abstinence by confinement, no appreciable acquisition of recovery skills and remains at very high risk of immediate continued use/relapse and functional deterioration. Has not been amenable to previous Level I treatment because would not attend.
- *Treatment Service Needs.* Needs near-daily monitoring and structure to overcome pattern of habitual use, impulsive behaviors and susceptibility to relapse triggers. Needs relapse prevention interventions including relapse trigger identification and refusal skills rehearsal, guidance in support of alternative prosocial leisure activities and peer group.
- *Placement.* Dimensional service needs met by Level II.5 placement.

Dimensional Assessment, Treatment Service, And Placement Considerations

Dimension 6

- *Assessment*. GM is supportive but lacks the personal resources to effectively sustain treatment. Peer group is predominantly substance using.
- *Treatment Service Needs.* Needs family intervention including training for GM on monitoring, home behavior negotiation and management, utilization of services and system (juvenile justice) leverage.
- *Placement*. Dimensional service needs met by Level II.1 placement.

Dimensional Assessment, Treatment Service, And Placement Considerations

Integrated Multi-Dimensional Placement

- Based on the criteria for each of the individual assessment Dimensions above, the PPC decision rules lead to an overall recommendation for a Level II.5 placement.

Variation A

- Runs away after 2nd day in II.5

Variation B

- While in detention she was involved in repeated dangerous aggression

Variation C

- The evaluation was postponed until 2 weeks after release from detention, during which time her experimentation with oxycontin has progressed

Variation D

- She remains abstinent during the first week of Level II.5, attends several 12 step meetings and is surprised that it's "not as stupid as I thought…",

Variation E

- She has a psychiatric evaluation, begins to see a therapist, and is considering an antidepressant trial though has concerns that "I'm not crazy…"

Variation F

- Misses several days during 1st week of II.5 and reports use of MJ and alcohol over weekend

Variation G

- She doesn't show up at II.5, GM says "can't make her come.."

Variant H

- Primary substance is heroin

Variation I

- She has had numerous previous failed attempts at treatment

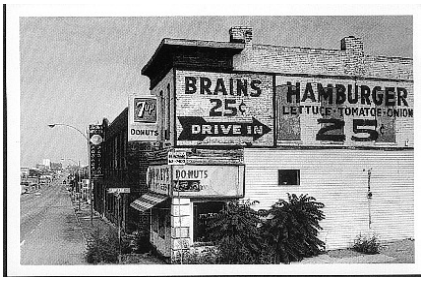
Variation J

- She has had previous psychotic symptoms during periods of heavy cannabis use. Slightly suspicious now "you all are trying to get me in too deep…"

Take Home Messages

- The six ASAM Criteria assessment dimensions are helpful to guide treatment and placement
- Treatment planning is based on individualized needs of the patient
- Be thoughtful about who goes where and who needs what
- Treatment engagement is a great place to start
- Adapt flexibly to the adolescent and family in front of you
- Always have a plan!

Hypothetical Miracle Cures



Treatment Works

- Use it!
- **We Need More Treatment!**

Resources

Lighthouse Institute, Chestnut Health Systems
http://www.chestnut.org/LI

National Institute on Drug Abuse (NIDA)
http://www.drugabuse.gov

http://www.drugabuse.gov/patients-families

NIDA for teens
http://teens.drugabuse.gov

The Partnership at drugfree.org
http://www.drugfree.org

SAMHSA co-occurring info
http://www.samhsa.gov/co-occurring/

Resources

SAMHSA's Registry of Evidence-Based Programs and Practices
http://www.nrepp.samhsa.gov/ViewAll.aspx

SAMHSA's Web Guide

http://www.samhsa.gov/ebpwebguide/